CMS MEDICAL POLICIES

1. A-Allergic Rhinitis and Sinusitis
2. A-Allergy to Bee Sting
3. A-Asthma
4. Arthritis – Osteoarthritis
5. Bone Mineral Density Testing
6. Bone Stimulator Policies
7. Breast Cancer – Diagnosis and Treatment
8. Breast Reconstruction
9. Bunions
10. Burns
11. Cardiac Stress Testing
12. Cardiac Thallium Scan
13. Carpal Tunnel Syndrome
14. Cholecystitis and Cholelithiasis
15. Chronic Fatigue Syndrome
16. Colonoscopy
17. Colposcopy
18. CT or MRI of Spine
19. D & C
20. Dental
21. Dental 2
22. Dermatology
23. Dupuytrens Contracture
24. EGD Endoscopy
25. Endometrial Ablation
26. Epidural Steroid Injection
27. Epilepsy
28. Erythropoietin
29. Ganglion Cyst
30. Gynecomastia
31. Headache
32. Headache – Migraine
33. Hearing Loss and Hearling Aids
34. Hemorrhoidectomy
35. Hepatitis C Policy
36. Hernias
37. Hirsutism
38. Hormone Therapy
39. Hydrocele
40. Hyperparathyroidism
41. Hysterectomy
42. Hysterectomy Worksheet

CMS MEDICAL POLICIES

43. Hysteroscopy
44. Incontinence
45. Insulin Pump
46. Laminectomy
47. Laparoscopy
48. Mammography
49. MRI of Knee
50. O-Ocular disease – Vision Loss or Eye Pain
51. O-Ophthalmology – Cataracts
52. O-Ophthalmology – Glaucoma
53. O-Ophthalmology Conditions P.1
54. O-Ophthalmology Conditions P.2
55. O-Ophthalmology follow-up guidelines P.1
56. O-Ophthalmology follow-up guidelines P.2
57. Ophthalmology – Pterygium
58. Optometry – Glasses
59. Otitis Media
60. Pain Management
61. Peptic Ulcer Disease
62. PET Scan
63. Physical Therapy, Occupational Therapy, and Speech Therapy
64. Plantar Fascitis
65. Podiatry
66. Prostatectomy
67. Rheumatology, including Rheumatoid Arthritis
68. Second Opinion
69. Septoplasty
70. Sinusitis
71. Sleep Apnea Form (CMS)
72. Sleep Apnea Study
73. TENS Unit
74. Thyroid Disease
75. Thyroidectomy
76. TMJ
77. Tonsillectomy and Adenoidectomy
78. Trigger Finger
79. Tympanoplasty
80. Tympanotomy
81. Varicose Veins
82. Vertigo
83. Wound Management

ALLERGY – Allergic Rhinitis and Sinusitis

The CMS program does not cover treatment or referral for common allergic rhinitis. Treatment or referral is covered only for disease which interferes with the ability to function and work.

Criteria for Referral and possible Desensitization

Patient History (two of three must be present)

1. Chronic symptoms, at least 3 days per week
2. Facial pain
3. Chronic purulent discharge

Physical Exam (two of three must be present)

1. Facial tenderness
2. Green/yellow discharge
3. Swelling and polypoid changes in the nose

Medication failure (all three)

1. Decongestants and/or antihistamines
2. Antibiotics for 6 weeks
3. Nasal steroids and/or nasal Cromolyn Sodium

X-Rays

Sinus imaging (plain films or CT scan) showing evidence of infection

ALLERGY – BEE STING

The CMS program covers Bee Sting Allergy kits for a history of definite systemic allergic reaction to bee stings. Referral for consultation and desensitization is based on the following criteria.

Criteria for Referral and possible Desensitization:

Patient History (all three)

1. Respiratory distress, acute urticaria or hypotension after a bee sting (history of anaphylaxis)
2. Reaction of bee sting is remote from the local reaction, at least 6 inches from sting
3. Personal risk at work or at home for bee sting exposure

Physical Exam (not required if history is clear or reaction documented by past medical records)

Evidence of allergic reaction remote from the site of the sting, including hives (urticaria), respiratory distress or hypotension

ALLERGY – ASTHMA

Mild intermittent, mild persistent and moderate persistent asthma are managed at the primary care level. Severe asthma, defined as requiring continuous systemic steroid therapy and a history of hospitalization, should be referred to an allergy or pulmonary specialist. Desensitization is covered by CMS only for asthma which interferes with function or work.

Criteria for Referral and Possible Desensitization

Patient History (at least one)

1. Life threatening
2. Asthma not responding to maximum medical therapy
3. Multiple ER visits, > 2 per year, or hospitalization

Treatment failure (at least two agents)

1. B-Agonists, including long acting
2. Theophylline
3. Cromolyn Sodium
4. Inhalation corticosteroids for 3 or more months

Tests

Pulmonary function testing which shows severe reversible disease

ARTHRITIS – Osteoarthritis

Criteria for referral to Orthopedic Surgery and Physical Therapy –
Referral to Orthopedic Surgery is only allowable if the patient requires surgery to function at work or with daily activities. Joint replacement for Osteoarthritis is not a CMS benefit. Physical therapy is approved only if rehabilitation is necessary.

Patient History (three of four)

- Restriction of daily activities
- Interferes with current work
- Failure to respond to medications - 3 month trial
- Failure to respond to physical therapy (Orthopedic referral)

AND

Physical Exam (two of four)

- Tenderness with movement
- Decrease range of motion
- Muscle wasting
- Deformity

AND

Imaging

- Evidence of moderate to severe joint changes

Bone Mineral Density (BMD) Testing

The CMS program covers only diagnostic evaluation to confirm the presence of suspected disease and provide critical treatment. Screening BMD is not covered. There must be evidence of likely or present osteoporosis or other metabolic bone disease.

Criteria for BMD Testing

- Patient has vertebral abnormalities as demonstrated by X-ray to be indicative of osteoporosis, low bone mass (osteopenia), or vertebral fracture.
- Glucocorticoid therapy equivalent of 7.5 mg of prednisone or greater per day for 3 months or longer, or the equivalent of 5 mg of prednisone or greater for 6 months or longer.
- Patient has hyperparathyroidism.
- Patient is being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug therapy.

BONE GROWTH STIMULATOR – Prior Authorization Criteria

Although bone stimulators have been used in a variety of clinical settings, the following requirements, adapted from the MediCal program (2/07 criteria), limit their utilization to the following situations:

1. Nonunion of long bone fracture - approve bone stimulator purchase or rental when nonunion (absence of healing) has been established for 6 months or more. Serial radiographs must include a minimum of 2 sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

2. As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site or for those undergoing a multiple level fusion. A multiple level fusion involves 3 or more vertebrae.

3. Failed fusion, where a minimum of 9 months has elapsed since the last surgery.

4. Congenital pseudoarthrosis is an indication for bone stimulation, requiring only confirmation the patient possesses this condition.

5. If surgery has been preformed in an attempt to induce healing of the bone fracture or nonunion via bone graft or internal fixation, the six or twelve month duration begins from the date of the surgery. The surgery date and procedure performed should be included with the TAR. CMS will cover the bone stimulation only to promote healing which has ceased or never began, not to facilitate an ongoing healing present at the site of defect. This also applies to surgery for congenital pseudoarthrosis.

6. Although the pulse generator is returned to the manufacturer, the device is billed as a purchase because the manufacturer does not provide the generator separately from the coils. Whenever possible, attempt to rent the device for one fee which will cover any periods up to one year. Use HCPCS Code E1399 (Miscellaneous – By Report) for rental, along with modifier – Y6, indicating a taxable rental.

7. If the device is approved as a rental, authorize for a one year period. Any reauthorization request should be denied, because if the OBS has failed to produce complete union within one year's time, the device is not effective in that case.

8. Use modifier 0Y7 with HCPCS Code E0747, indicating a taxable DME purchase, or modifier - HCPCS Code E1399, indicating a taxable DME rental (See Table 1). The following procedure code facilitates the identification and reimbursement of the use of electrical stimulation to aid bone healing:

DPT-4 Code	Description
20974	Electrical stimulation to aid bone healing; noninvasive

Cast applications may be billed in addition to CPT-4 code 20974

BREAST CANCER – DIAGNOSIS AND TREATMENT

The CMS program follows California law for the diagnosis and treatment of breast cancer. Bold emphasis added.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.6 of the Health and Safety Code is repealed.

SEC. 2. Section 1367.6 is added to the Health and Safety Code, to read:

1367.6. (a) **Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.**

(b) No health care service plan contract shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) **Every health care service plan contract shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the enrollee's participating physician.**

(d) **Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy.** Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

(f) As used in the section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

SEC. 3. Section 1367.65 of the Health and Safety Code is amended to read:

1367.65 (a) On or after January 1, 2000, every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse midwife, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) Nothing in this section shall be construed to prevent application of co-payment or deductible provisions in a plan, nor shall this section be construed to require that a plan be extended to

cover any other procedures under an individual or a group health care service plan contract. Nothing in this section shall be construed to authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

SEC. 4. Section 10123.8 of the Insurance Code is repealed.

SEC. 5. Section 10123.8 is added to the Insurance Code, to read: 10123.8 (a) Every policy of disability insurance that provides coverage for hospital, medical, or surgical expenses, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No policy of disability insurance that provides coverage for hospital, medical, or surgical expenses shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c)Every policy of disability insurance shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participation physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(e)As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

(f) As used in this section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

(g) For the purposes of this section, disability insurance does not include accident only, credit, disability income, specified disease and hospital confinement indemnity, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

SEC. 6. Section 10123.81 of the Insurance Code is amended to read:

10123.81 On or after January 1, 2000, every individual or group policy of disability insurance of self-insured employee welfare benefit plan that is issued, amended, or renewed, shall be deemed to provide coverage for at least the following, upon the referral of a nurse practitioner, certified nurse midwife, or physician, providing care to the patient and operating within the scope of practice provided under existing law for breast cancer screening or diagnostic purposes:

a) A baseline mammogram for women age 35 to 39, inclusive.
b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physician's recommendation.
c) A mammogram every year for women age 50 and over.

Nothing in this section shall be construed to require an individual or group policy to cover the surgical procedure known as mastectomy or to prevent application of deductible or co-payment provisions contained in the policy or plan, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

Nothing in this section shall be construed to authorize an insured or plan member to receive the coverage required by this section if that coverage is furnished by a nonparticipating provider, unless the insured or plan member is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

BREAST RECONSTRUCTION

The CMS program covers breast reconstruction only in relation to breast cancer treatment, following breast cancer surgery. In rare instances, breast reconstruction may be approved for removal of a prosthesis if it is extruding and interferes with the ability to work.

Criteria for Authorization

- Following or concordant with breast cancer surgery
- Treatment associated abnormalities or deformities
- Removal of prosthesis from fibrosis or extrusion (work history required)
- Replacement of prosthesis if mastectomy due to breast cancer
- Nipple reconstruction (for breast cancer)
- Breast prosthesis and bras (2) covered every two years, for replacement

BUNIONS

Criteria for referral to Podiatry or Orthopedics for surgery

Patient History

- Symptomatic bunions which interfere with daily function or work.

AND

Physical Exam

- Marked deformity is present

AND

Radiology

- X-ray confirmation of severe deformity
- HV angle greater than 40 degrees
- Marked lateral deviation
- Some overlapping of second toe
- Subluxation of lateral sesamoid bone

AND

Work History

BURNS – Burn Center Policies for Major Burns

The CMS Program covers up to 5 days of UCSD Burn Center level of treatment and reimbursement. Any extension of this coverage requires Medical Director review and approval.

Criteria for Approval of Additional Burn Center Level Coverage

- Patient has 30% or more 3rd degree burns, OR
- Patient has inhalation burns requiring intubation
- Level of care required is intensive for both a medical and burn care

Rule of Nines

Wallace's Rule of Nines provides an approximation of the area of skin burned. It divides the body into units of surface are divisible by nine, with the exception of the perineum. Charts are available in most burn units. The Rule of Nines is accurate for adults but not for children due to the relative disproportion of the body surface area.

The following are the respective percentages of an adult body surface area:

- Head and neck front and back – 9%
- Each upper limb total front and back – 9%
- Chest and Abdomen front – 18%
- Back side, thorax and low back – 18%
- Perineum – 1 %
- Each lower limb total for front and back – 18%

CARDIAC STRESS TESTING

Referral for Cardiac Stress Testing is based on a clear risk for coronary artery disease. Screening Cardiac Stress Testing is not approved by the CMS program. The patient must have two or more cardiac risk factors (age over 40, positive family history, smoking, hypertension, hyperlipidemia, diabetes, and obesity). Exercise Cardiac Stress Testing is done on all patients except those unable to exercise on the treadmill. Medicated Cardiac Stress Testing (Adenosine, Dipyridamole) is approved based on the following:

Criteria for Medicated Cardiac Stress Testing

History (one of any three)

- Incapable of exercising on a treadmill
  - Difficulty maintaining balance
  - Excessive obesity
- Reactive airway disease – risk of bronchospasm
- Frail and elderly

AND

Conjunction Testing

- Echocardiography
- Nuclear scan

CARDIAC THALLIUM SCAN

Criteria for Approval: A cardiac thallium scan is done to evaluate the chambers and structure of the heart while exercising. It is used to evaluate circulation to the heart muscle. A cardiac thallium is more accurate in evaluation evidence of coronary heart disease than a regular exercise stress test.

Patient History Required:

- Prior treadmill testing
- Abnormal EKG – 1mm or greater deviation from normal baseline
- Bundle Branch Block
- Unstable angina
- Female > 45 or surgical menopause with chest pain or anginal equivalent

CARPAL TUNNEL SYNDROME

Most patients with carpal tunnel syndrome improve and recover in the primary care setting. For many patients, carpel tunnel syndrome is an overuse injury and a change in work position and rest resolve the problem. For patients with persistent carpal tunnel syndrome despite rest and wrist splinting, referral to an orthopedic surgeon for injection or surgery may be necessary. Referral to Neurology for nerve conduction study is unnecessary unless the diagnosis is uncertain.

Referral Criteria

Patient History (one of two required)

- Failed three months of conservative management
  - Regular use of NSAIDs and night splints
  - Trial of changed work positioning
- Interferes with A.D.L

AND

Physical Exam (one of three required)

- Positive Tinel an/or Phalen test
- Atrophy or weakness of the thenar muscles
- Documented nerve impairment on Nerve Conduction Velocity testing (done only if the physical exam is uncertain)

AND

Work History (a procedure will help the patient continue or return to work)

CHOLECYSTITIS AND CHOLELITHIASIS

Criteria for Surgery – The CMS program covers cholecystectomy only for the removable of symptomatic gallstones causing clinical obstruction or infection. The CMS program does not cover surgery for asymptomatic gallstones

History (any one of four)

- The diagnostic tests verify the presence of gallstones
- History of Jaundice
- Two documented episodes of abdominal colic or RUQ pain
- The presence of nausea/vomiting, chills and fever, leukocytosis

AND

Physical (one of two)

- The patient has abdominal guarding/tenderness
- A mass in the RUQ

AND

Diagnostic Tests

- Ultrasound or CT scan documents presence of gallstones

Chronic Fatigue Syndrome

Criteria for Referral

History (All must be present)

- Severe unexplained fatigue for > 6 months
- Functionally impaired
- Has a date of onset and unrelated to psychological stress

AND

Symptoms (at least three are present)

- Memory or concentration complaints
- Sore throat
- Tender lymph nodes
- Muscle pain
- Multijoint pain
- New pattern of headaches
- Unrefreshing sleep
- Postexertional malaise lasting more than 24 hours

AND

Treatment (all of these have been met)

- Judicious use of medication to ameliorate symptoms
- Graded exercise or Rehabilitation measures
- Hypothyroidism has been ruled out
- Depression has been ruled out or treated

COLONOSCOPY

Criteria for Referral: CMS does not cover screening colonoscopy. Any one of the following indications must be met.

History (at least one present)

- Positive stool culture or O&P study
- Unexplained iron deficiency anemia
- Acute diarrhea - following recent antibiotic therapy
- Melena - normal UGI endoscopy
- Rectal bleeding unexplained
- Abnormal x-ray findings, mass, lesion or ulceration
- Chronic diarrhea
- Ulcerative colitis
- Crohn's Disease

OR

Therapeutic (at least one present)

- Excision of polyps
- Removal of foreign body
- Dilatation of stricture
- Control active bleeding

OR

Surveillance (at least one present)

- With colon polyps – every 3-5 years, if large (greater than 2 cm), may repeat in 3-6 months, if multiple adenomas, repeat at 1 and 4 years.
- Following polypectomy - 1 year, then 1-3 year intervals
- Following removal of colon cancer, 6 months, 1 year, q 2-3 years
- Ulcerative colitis - q 1-2 years after 8th year when stable
- Left sided colitis - q 1-2 years after 15th year when stable
- Family history of colon cancer
  - Three 1° relatives - q 3-5 years from age 20
  - One or 2 1° relatives - q 3-5 years from age 40

COLPOSCOPY - Cervical

Criteria for Referral or Performing the Procedure in the Clinic:

Colposcopy is performed to evaluate abnormal Pap Smears and to allow for guided cervical biopsies. Not all atypical Pap smears require Colposcopy, and Colposcopy should not be routinely repeated if the cervical abnormalities are minor. Repeat Pap smears are an acceptable way to monitor mild cervical pathology, especially if HPV testing is negative.

Colposcopy is indicated for cervical cytology demonstrating:

Atypical Squamous Cells of Undetermined Significance (ASCUS):
First treat specific infections and repeat PAP in 3-6 months
Colposcopy with suspicious cervical or vaginal lesion

- ASCUS
  - 2 or more Pap reports are abnormal
  - if HPV test is positive

- SIL (Moderate Dysplasia, CIN I)
  - repeat Pap smear in 3-6 months
  - visible abnormality

- HSIL (Moderate and Severe Dysplasia, CIN II, CIN III)

CT or MRI of Spine

Criteria for Performing Advancing Imaging of the Cervical, Thoracic or Lumbar Spine: Advanced imaging of the spine should be performed for specific indications and not simply because of pain. In the presence of chronic pain, advanced imaging is done only if there are symptoms of neurologic impairment or suspicion of a lesion in the bone. CT is done to evaluate the bone tissue, and MRI is preferred for looking at the spinal cord and nerves.

- Suspected fractures and dislocations (not clear by plain x-rays) (CT)
- Disk herniations causing neurologic signs or symptoms (MRI)
- Previously documented spinal stenosis (MRI)
- Previous spinal surgery and demonstration of non-union on X-ray or positive Bone Scan (CT)
- Significant trial of conservative therapy including anti-inflammatory medications and physician supervised home exercise/physical therapy (MRI)
- Chronic pain in a patient at risk for cancer (CT)
- Localized tenderness of a vertebral body suggesting osteomyelitis (CT)

DILATATION & CURETTAGE OF THE UTERUS (D&C)

Criteria for Referral: D & C is performed less commonly today with better procedures for evaluating the tissue in the uterus. For diagnostic purposes, endometrial biopsy, hysteroscopy and ultrasound are often used when D & C had been done in the past.

Patient History (either one of these present)

- Excessive bleeding with a suspicion of tissue present
- Post-menopausal bleeding to evaluate for endometrial cancer
- Recurrent post-menopausal bleeding (for treatment, other tests are performed for diagnosis)

Addendum:

- There is no indication for performing a D&C in an adolescent
- Heavy bleeding is usually better treated with hormones
- Office endometrial biopsy is the first step to evaluate for endometrial cancer, and hysteroscopy is preferable to a D & C as the second test
- Bleeding associated with pregnancy is not a covered CMS benefit

DENTAL

Criteria for Referral and Services Performed in the Clinics

The County Medical Services Dental Program is designed to provide EMERGENCY dental treatment to alleviate a patient's IMMEDIATE source of dental pain and does not provide comprehensive preventive or restorative dental care. Dental clinics will provide emergency dental care based on the CMS basic dental service list; all other procedures/treatments must be medically indicated and require prior approval.

Emergency Care Only (for acute pain)

- Site specific x-rays
- Urgent extractions
- Palliative Restoration fillings
- 2 visits allowed, then submit Rx plan

Endodontics (Root canal treatment): TAR Required

- Anterior teeth (6-11 and 22-27) only. The final composite restoration is covered under the basic encounter fee. The composite restoration only is covered. (Patient may self-pay for a crown.)

Dental prosthesis: CMS covers these only for critical function purposes and not for cosmetics. In most circumstances, only the anterior teeth are covered.

- To replace recently extracted teeth only after adequate healing
- To allow pursuit of employment (documentation required)
- Necessary to ensure adequate medical treatment (documentation of health condition required)
- Repair or replacement of an existing appliance – one time in 12 months (once a year) is covered

Not Covered:

- Routine dental examinations, x-rays, cleaning, or prophylaxis
- Restoration of asymptomatic teeth
- Comprehensive periodontal treatment
- Permanent crowns and bridges
- Dental prosthesis not meeting the above criteria
- Orthodontia

- Elective services and/or medications not required to treat a potentially disabling or life-threatening illness or condition
- Immediate dentures and immediate partial dentures

The Following should be submitted with Dental TARS:

- Illustration of mouth with teeth numbered
- X-rays of the requested teeth.

Specific Dental Prostheses:

Upper or lower stayplate: Dental clinics will frequently have CMS pay for a stayplate with allowable teeth (anterior only) and the patient will pay for those not covered.

- Recently extracted teeth (within 6 months)
- Evaluation of the remaining teeth (must be good dentition)
- Anterior only (6-11, 22-27)
- Repair or replace if necessary once every 12 months
- Work history (Denture form attached) Apply standard criteria

Upper or lower denture

- Work history (New form attached) Apply standard criteria (anterior teeth only)

Aveleoplasty: If patient does not already have dentures, need a work history. Approve for re-fit when patient has existing dentures

Stainless steel crowns are only covered if a posterior tooth has no integrity, but the remaining teeth are in good shape

Oral Surgery: CMS only covers Oral Surgery for critically necessary services. Prior treatment authorization required (TAR).

Wisdom teeth (#1, 16, 17, 32) - only symptomatic 3rd molars are covered. Soft tissue impaction can be extracted in the dental clinic.

Oral lesions to remove or biopsy for cancer

CMS Program Summary of Dental Policies

	C	SUP	TAR	PAS	NC
The following procedures may be provided, as Necessary as part of the basic encounter prior Authorization not required:					
• Simple extractions – non-restorable Symptomatic teeth	X				
• Postoperative care – including treatment for "dry socket."	X				
• Reimplantation and stabilization of avulsed Tooth	X				
• Gross periodontal debridement – all symptomatic areas	X				
• Incision and drainage of periodontal abscess	X				
• Open and drainage of endodontic abscess - teeth 6-11, 22-27	X				
• Anterior composites – to relieve painful caries, includes liners and bases as needed	X				
• Posterior amalgams – to relieve painful caries, includes liners and bases as needed	X				
B. Conditions Requiring Prior Authorization			X		
1. Curettage and Root Planning For Pain Relief					
Subgingival curettage or root planning for pain relief of pain when periodontal debridement and oral hygiene instructions fail to relieve the patient's symptoms is covered with prior authorization. Please submit the following with your request:			X		

Doc Req – Documentation Required
C= Covered
Sup= Requires supplemental form
TAR= Requires prior approval by CMS after long TAR form submitted
NC= Not Covered

DERMATOLOGY

Criteria for Referral and Procedures

Referral and Office biopsy is allowed for the following:

- Possible Melanoma
- Basal Cell Cancer (BCC)
- Squamous Cell Cancer
- Other Malignant neoplasm
- Dysplastic nevi

Referral for Certain Conditions:

Pruritis (Itching): Most itching in primary care is due either to excessive use of soap (dry skin) or neurodermatitis. The primary care physician is able to evaluate and treat most causes of pruritis, including primary and secondary conditions. Referral is approved to Dermatology only after a thorough primary care evaluation is done and the cause is uncertain or the treatment is ineffective. The patient history, physical findings and previous treatments must be well documented.

Rash: Most skin rashes are diagnosed and treated in primary care. Referral to Dermatology is approved when the diagnosis and treatment remain uncertain. The patient history, physical findings and previous treatments must be well documented.

Acne: The CMS program does not cover the treatment of mild or moderate acne. Referral to Dermatology would only be allowed for severe, cystic, inflammatory acne. The patient history, physical findings and previous treatments must be well documented.

Psoriasis: Referral to Dermatology is approved only for psoriasis in multiple areas which is actively inflammatory and unstable. The patient history, physical findings and previous treatments must be well documented. Treatments for psoriasis which are not on formulary, or procedures such as PUVA, require prior authorization.

Actinic Keratosis: Most Actinic Keratosis is managed by primary care. Referral to Dermatology is allowed for extensive disease on exposed areas. The patient history, physical findings and previous treatments must be well documented. Treatments which are not on formulary require prior authorization.

DUPUYTRENS CONTRACTURE

Criteria for Referral and Surgical Treatment: Referral for this condition is only approved in cases in which the disease interferes with work or activities of daily living.

Patient History (both must be present)

- Involvement of the palmar and digital fascia
- Flexion deformity of the fingers

AND

Physical Exam (both must be present)

- Characteristic nodule or cord in the palmar fascia
- Metacarpophalangeal joint contracture >30 degrees

AND

Work History

ESOPHOGASTRODUODENOSCOPY (EGD)

Criteria for GI referral for this procedure: EGD is also known as Upper GI Endoscopy and is performed when direct visualization of the upper GI tract is necessary. Biopsy of the esophagus, stomach and duodenum can also be done by EGD.

Patient History

- Persistent symptoms of heartburn or GERD despite 2 months of PPI therapy.
- Age of onset of GERD age 50 or later.
- Extraesophageal symptoms, e.g., hoarseness, chest pain, wheezing
- Complicated GERD, e.g. dysphagia or iron deficiency anemia
- Symptoms of five years duration in patient > 50 years of age
- Failure of lifestyle modifications such as no smoking, caffeine, aspirin, alcohol and spices

Repeat EGD (may be done in 8–12 weeks)

- Erosive or Transitional cells present on initial biopsy

ENDOMETRIAL ABLATION

Criteria for Referral and the Procedure: Endometrial ablation is an alternative to hysterectomy for women with persistent excessive vaginal bleeding. It is also used for women with hypertrophy or polyps of the endometrial tissue. It has the advantage over hysterectomy in that it does not require major surgery and preserves the uterus.

Patient History (all should be present)

- Excessive vaginal bleeding in a woman who has completed their childbearing
  - profuse bleeding or repetitive periods
  - anemia due to acute or chronic blood loss
- No uterine or cervical pathology that would require hysterectomy
- No finding of remedial cause by hysteroscopy
- Failure of hormone treatment

EPIDURAL STEROID INJECTION

Criteria for Referral for this Procedure: Epidural steroid injection is indicated for chronic neck or back pain with radiculopathy. It is an alternative to surgery, and may reduce the need for pain medications. Approval is given for only one injection at a time.

Patient History

- Chronic neck or back pain with radicular symptoms present for at least 3 months.
- Conservative pain management has been used for at least 6 weeks without benefit

Physical Exam

- Evidence of neurologic signs (numbness, weakness or reflex changes)

Addendum: Injections limited to three in a given year, with at least 3 months separation between injections.

EPILEPSY (SEIZURE DISORDER)

Criteria for Referral and Vagus Nerve Stimulation (VNS): All patients with a current active seizure disorder should be seen by a neurologist at least once a year, even if seizure free. The number and types of seizure medications is changing frequently. Only a neurologist should remove seizure medication therapy. In those patients where medications are not effective for control, VNS or epilepsy surgery may be indicated.

Patient History (for VNS)

- Failure of at least three drugs as therapy to control seizures
  - Exclude discontinuance due to side effects and non-compliance.
- Patient has the ability to manage a VNS magnet

ERYTHROPOIETIN (Recombinant Growth Factor) Epogen, Procrit

Criteria for Approval of this Medication Therapy: The use of these medications has recently come under criticism for their failure to improve patient outcomes and their great expense. Medicare and other health insurance plans are increasing their restrictions on these medications. Erythropoietin is covered only for patients with severe anemia due to chronic kidney disease or cancer therapy to avoid blood transfusions.

Patient History (anemia criteria must be met for either condition)

- Recurring chemotherapy expected to cause bone marrow suppression
- Chronic kidney disease
- Anemia with hemoglobin (Hgb) less than 10 gm/dl or hematocrit (Hct) less than 30%

Addendum:

- Dosages are approved for one month at a time, and are continued only if Anemia criteria are still present
- Continuation of therapy for more than 6-8 weeks is not beneficial in the absence of response (e.g.<1 to 2 gm/dl rise in Hgb). Longer term use of the medications will not be approved in the absence of a response

GANGLION CYST

Criteria for Referral for Surgical Removal: Most ganglion cysts are painless and do not interfere with work or living activities. Approval for referral for surgery is limited to those patients that have a critically medical indication for surgery.

Patient History

- Pain which causes interference with work or essential activities
- Weakness or altered range of motion

Physical Exam

- Cyst or mass of dorsal or volar wrist
- Cyst or mass in other location causing a limitation of function

Addendum:

- 50% of ganglion cysts disappear without therapy.
- Regardless of therapy, reoccurrence is common.

GYNECOMASTIA

Abnormal enlargement of the breast in a male in usually due to hormonal imbalance or medications, especially anabolic steroids. The management of Gynecomastia is usually medical and a referral to endocrinology is indicated if the cause is unclear in the primary care setting. The basic work-up should be done in primary care, such as a carefully medication history and hormone levels. If the patient, especially a male, is in puberty, a small degree of temporary gynecomastia is normal and is referred to as thelarche. CMS does not cover surgery for Gynecomastia unless there is a malignancy.

Patient History (required to consider referral)

- Duration of gynecomastia
- Medication History
- Use of alcohol
- Mammogram report (if done)
- Significant weight gain
- History of Liver disease
- Onset of puberty

AND

Physical Exam

Unilateral or bilateral
Increased adipose vs breast tissue

HEADACHE

Most patients with headache are managed by primary care, including migraine. The following are criteria which may lead to a referral to a neurologist or other headache specialist. Advanced imaging (CT or MRI) is only indicated for headache when there are neurologic signs, usually an abnormal neurologic exam. CT is generally done in the emergency setting to r/o hemorrhage or mass lesion. MRI is preferred to evaluate for brain tumors and other intracranial lesions.

Note: A separate medical policy follows for Migraine

Patient History

- Sudden onset of new severe headache
- Progressively worsening headaches
- Onset with exertion, coughing, straining, and/or sexual activity
- Associated symptoms such as:
  - Drowsiness, confusion, memory loss
  - Chronic malaise, myalgia, arthralgia
  - Fever
  - Progressive visual disturbances
  - Weakness, clumsiness, loss of balance
  - Onset of first headache after the age of 50 years

Physical Exam

- Abnormal vital signs, especially fever or high blood pressure
- Altered consciousness or cognition
- Meningeal irritation ('stiff neck')
- Papilloedema or fundal hemorrhage
- Pupils unequal and/or poorly reactive
- Weakness or sensory loss in face or limbs
- Reflex asymmetry or abnormal plantar response
- Clumsiness or loss of balance
- Tender temporal arteries with diminished pulse

HEADACHES - MIGRAINES

Criteria for Referral: The PCP is able to evaluate and manage most patients with migraines. Referral to a neurologist is only approved for a failure to respond to treatment or positive neurologic findings.

Patient History

- Dissimilar headache (One item)
  - Decreased alertness
  - First headache after age 50
  - "Worst headache ever"
  - Headache with exertion

- Failure of adequate trial of management (Two of five)
  - Nonsteroidal anti-inflammatories
  - Isometheptine
  - Ergotamine
  - Butalbital
  - Triptans (see below)

Physical Exam

- Neurologic exam performed, any focal abnormality
- Nuchal rigidity
- Abnormal vital signs

Criteria for the approval of a triptin medication (e.g. Imitrex)

- Requested by a Neurologist

- Requested by PCP:
  - Failed a non-steroidal medication
  - Failed other generic anti-migraine medications

HEARING LOSS

The CMS program covers referral, testing and treatment for hearing loss which impairs a person's ability to work and handle activities of daily living. A work history is usually required for any treatment

Criteria for Referral:

Patient History (At least one of these is required)

- Infection or trauma suggesting a Conductive Hearing loss. With infection (otitis media), the hearing loss must be present for at least 2 months
- Otosclerosis
- Sensorineural Hearing loss with:
  - Lesion of cochlea
  - Tinnitus
  - Gait imbalance
  - Unilateral hearing loss
- A family history of a genetic hearing loss
- Sudden onset of a major hearing loss
- Recurrent dizziness with hearing loss
- Poor speech discrimination

Physical Exam (At least one of these is present)

- Otoscope Exam
  - no presence of blood, pus, cerumen plug, or foreign objects (all of which are treated in primary care)
  - Abnormal findings of the tympanic membrane or middle ear which suggest a permanent or chronic problem

Tests

- Audiogram shows evidence of more than a 30 decibel deficit

Criteria for Hearing Aids (Unilateral):

- To correct significant disability with work or ADL
- Replacement or repair-1x per 12 month period
- Bi-aural hearing aids require visual acuity justification

HEMORRHOIDECTOMY

Criteria for Referral: Most thrombosed external hemorrhoids resolve with warm baths, topical creams and fiber in the diet. CMS does not cover referral for treatment of external hemorrhoids unless the following criteria are met. Internal hemorrhoids that have recurrent bleeding and/or prolapse may warrant a procedure if they interfere with work or daily activities.

Patient History (any one of these present)

- Repeated or persistent prolapse or thrombosis with severe pain (internal hemorrhoids)
- Recurrent bleeding unresponsive to conservative treatment (either external or internal hemorrhoids)
- Thrombosis with severe pain not responsive to warm baths or medications over 3 days

Physical Exam

- Acute irreducible prolapse of internal hemorrhoids

Hepatitis C

Criteria for Referral: A large number of CMS patients are Hepatitis C antibody positive. Of these patients, 55-85% will be chronically infected. 80-95% of patients with a positive Hepatitis C antibody will not develop serious liver disease such as cirrhosis or liver failure. The CMS program will only approve for referral and treatment those patients who are candidates for treatment.

In order to use limited CMS funds wisely for this population, only patients with some evidence of active liver disease from Hepatitis C will be referred for treatment. Referral requests should include: Hepatitis C antibody test, liver function tests (especially ALT) and information about other possible causes of liver disease such as active alcoholism, hyperlipidemia, weight, and whether there is ongoing IV drug use.

For those patients who are HCV antibody positive, have elevated liver function tests, and do not have another apparent cause for liver disease, HCV RNA testing should be done to evaluate for chronic infection. If the HCV RNA testing is positive, and the other criteria are met, a referral to GI for consideration for treatment will be approved. Also, if the HCV RNA testing is positive, HCV Genotype testing may be done by your clinic (if required by the GI referral specialist) or by the specialty clinic.

Patients who are Hepatitis C antibody positive and have normal liver function tests should be followed clinically at the primary care level. Also, patients with ongoing alcoholism, IV drug use, fatty liver or other causes of liver disease should have these conditions managed before consideration for hepatitis C referral for treatment.

These links cover the current CDC fact sheet and recommended Clinical Guidelines for the Diagnosis and Treatment of Hepatitis C:

http://www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm

https://www.aasld.org/eweb/docs/hepatitisc.pdf

HERNIAS – Surgical Correction

Criteria for Referral: The CMS program does not cover elective surgery for hernia repair. Current clinical guidelines support "watchful waiting" for hernias in patients who are not at high risk for incarceration. The near-elderly and those persons doing heavy manual labor are at risk. The CMS program will only cover for referral and treatment of hernias that are symptomatic and interfere with work or activities of daily living.

Inguinal Hernia ♦ Incisional Hernia ♦ Ventral or Periumbillical Hernia

Patient History (any one of these must be present)

- Pain of significant duration
- Affects employability

And

Physical Exam (one of two)

- Difficulty reducing hernia
- Incarcerated hernia

Hirsutism

Criteria for Referral: Hirsutism is the excessive growth of hair in women. A family and cultural history are important to be sure that the hair growth is not normal. People from Mediterranean countries often have excessive hair growth including some masculinization of women. Hirsutism is triggered by androgen production, and the work-up focuses on hormonal causes. The work-up can usually be done in primary care, but based on the criteria below, a referral to an endocrinologist, or an gynecologist may be appropriate.

Patient History (all are present)

- Symptoms suggestive of Polycystic Ovarian Disease or Adrenal Hyperplasia, Hyperandrogenic, insulin-resistant, acanthosis nigricans syndrome and Androgen secreting tumors
- Absent familial predilection for hirsutism
- Evaluation of patient's medications

AND

Physical Exam (both are done)

- Confirmation of hirsutism
- Pelvic ultrasound

HORMONE THERAPY

Criteria for use of specific agents:

Oral Contraceptives Pills (OCP): The CMS program does not cover contraceptive care. OCPs are only approved for specific medical indications:

Patient History

- Dysfunctional bleeding
- Polycystic ovary syndrome
- Hypothalamic amenorrhea
- Endometriosis
- Recurrent functional ovarian cysts

Progesterone Challenge (usually 10-14 days)

As an alternative to surgery or prevention of surgery

- Dysfunctional bleeding
- Secondary Amenorrhea
- Hb < 10 mg/dl

Lupron

Prescribed only as recommended by a gynecologist

- Filrocols
- Endometriosis
- Limited to 3 mg (1x per month)

Hormone Replacement Therapy (HRT): CMS does not cover HRT for normal menopause

May be prescribed for:

- Surgical menopause < 40 years of age (include date of surgery), and approve only to age 50
- Osteoporosis, documented by Dexa Scan
- Progesterone used with estrogen if uterus present

HYDROCELE

Criteria for Referral and Surgery: Hydrocele is rarely a significant health problem and CMS does not cover routine referral or correction.

Patient History

- Painless mass
- Vague, gradual symptoms may occur with enlargement

Physical Exam

- Mass or focal swelling
- Cystic
- Freely movable
- Non-tender
- Transluminates with light
- There may be testicular atrophy
- Usually left-sided

Diagnosis

- Based on translumination with a lack of any mass or solid tissue. Ultrasound may be performed if exam is uncertain

Management

- Observe for spontaneous resolution or if any change
- No treatment necessary if stable
- Aspiration may be performed if enlarging, causing discomfort or interfering with work
- Criteria for surgical removal
  - persistent pain
  - interferes with work

HYPERPARATHYROIDISM (Causing hypercalcemia)

Criteria for Referral and Surgery:

Patient History and Laboratory Findings:

- Occurrence of renal stones
- Progressive bone loss (by Dexa Scan)
- Serum CA > 11.5 mg/d or simultaneous elevation of serum PTH and Calcium indicating hyperparathyroidism

HYSTERECTOMY

Criteria for Referral and Surgery: The CMS program does not cover elective hysterectomy. The procedure is only approved when critically necessary for the woman's health. Abdominal, vaginal or laparoscopic hysterectomy is only approved when clinically necessary. Less invasive procedures, such as uterine ablation therapy should always be considered.

Patient History

- Cancer or pre-cancer of the uterus, cervix or ovary
- Recurrent endometrial hyperplasia after adequate treatment with curettage and progestin therapy
- Rapid growth of fibroids which are causing health problems such as persistent heavy vaginal bleeding
- Progressive dysmenorrhea or menorrhagia unresponsive to D&C, hysteroscopy and hormone therapy
- Refractory menorrhagia for 3-6 months despite adequate hormone therapy. There must be a clinically significant drop in Hb or Hct.

OR

Physical Exam

- The presence of uterine fibroids > 16 wks gestational size

AND

Hysterectomy worksheet required

REQUEST FOR AUTHORIZATION

Hysterectomy Worksheet

History

Age _____ Gravida_____ Parity _____

Symptoms:

- Recurrent Bleeding
  - Duration _____
  - Lowest Hb/Hct _____
  - (with documentation)
  - Current Hb/Hct* _____

  Treatment
  - Oral Contraceptives (3 cycles) _____
  - Depo-Provera (3 cycles) _____
  - D&C or Hysteroscopy* _____

- Intractable Pelvic Pain
  - Duration _____
    - Cyclic _____
    - Constant _____

  Treatment
  - Medications _____
  - Duration _____

- Presence of Fibroids
  - Size >16 weeks* _____

Physical Exam

- Pelvic Relaxation - Severity
  - Uterine Prolapse _____
  - Cystocele _____
  - Rectocele _____

- Pelvic Tenderness _____
- Abnormal Findings

_____

*provide documentation

HYSTEROSCOPY

Criteria for Referral and the Procedure: Hysteroscopy is an outpatient procedure allowing the physician to visualize the inside of the uterus. Hysteroscopy is superior to D&C for diagnosis of intrauterine pathology. Endometrial biopsies and endometrial ablation may be done as part of Hysteroscopy.

Patient History

- Postmenopausal bleeding
- Failure to find cervical or uterine pathology that would cause abnormal bleeding
- History of excessive uterine bleeding evidenced by profuse bleeding, repetitive periods lasting more than 8 days, or frequent periods at less than 21-day intervals
- Failure of appropriate medical therapy

AND

Physical exam and Diagnostics

- Pelvic exam
- Obtain cervical cytology
- Obtain endometrial sampling

INCONTINENCE

Criteria for Referral and Surgical Correction: Most urinary incontinence in women is managed by primary care with pelvic exercises and medication. Referral for surgical correction is only approved if critically necessary for employment or daily activities.

Patient History

- Duration of symptoms
- Thoroughly evaluated and treated with behavioral techniques and medication
- Patient has previously followed a mandatory voiding schedule with specific fluid intake, i.e. no caffeinated beverages
- Compliance with a pelvic exercise program (Kegels)
- Trial of medications for incontinence
- Alternative use of pessary offered to patient

AND

Physical Exam

- Assessment of estrogen status (evidence of atrophy).
- Adequate pelvic exam, R/O diverticula and fistulas, description of prolapse.
- Urine culture

INSULIN PUMP

Criteria for approval

- Request from Endocrinologist
- Patient must have **frequent** and **severe** glycemic excursions requiring visits to Physician, ER or Hospital.
- Significant ketosis
- Insulin reactions and/or ketoacidosis
- Blood glucose levels greater than 140 mg/dL preprandially and/or greater than 200 mg/dL fasting ("Dawn phenomenon")
- Glycosylated hemoglobin (HbA1c) greater than 8 percent
- Chronic renal failure or ongoing dialysis
- Intermittent insulin injection not a practical option for the patient

Note: If insulin pump in place and patient is doing well, CMS will provide supplies to maintain it.

LAMINECTOMY (SPINE SURGERY)

Criteria for Referral and Surgery: Surgery to the spine, cervical, thoracic or lumbar, is done for nerve impingement not responsive to conservative measures. Physical therapy and epidural steroid injections should be tried first in most cases.

Patient History

- Radiating pain from lumbar spine down leg
- Numbness of leg or foot
- Low back pain
- Bowel or bladder dysfunction

AND

Physical Exam

- ↓ sensation
- + contra lateral straight leg raising
- ↓ DTR (Deep Tendon Reflexes)
- ↓ muscle strength
- Change in gait
- Unequal deep tendon reflexes

AND

Diagnostics

MRI is the imaging of choice. A CT scan may be adequate if already done
- demonstrates positive disc protrusion
- spinal stenosis
- cord compression with neurological sign

LAPAROSCOPY (Gynecology)

Criteria for Surgery

- Chronic pelvic pain with no cause identified
- Abnormal ovarian findings
- Failure of conservative management (OCs, progesterone)
- Failure of GnRH Agonist (endometriosis)

MAMMOGRAPHY

Criteria for Imaging: The CMS program does not cover routine screening mammography. A diagnostic mammogram is only approved when critically necessary to evaluate some abnormality suggesting possible breast cancer.

- If the woman is less than age 40, refer to the Breast and Cervical Cancer Early Detection Program (BCCEDP)

- If greater than age 40, only if a mass, bloody discharge or other changes have occurred warranting a diagnostic mammogram.

MRI OF KNEE

Criteria for Imaging: An MRI of the knee should only be performed if the diagnosis or extent of the disease is unknown. Plain x-rays of the knees are done first, and if common osteoarthritis is found, an MRI is not necessary. A careful knee exam should also be performed before consideration is given for an MRI. An MRI of the knee should be performed before an Orthopedic consultation for most knee problems.

Patient History

- Aid in the diagnosis of meniscal tear
- Aid in the diagnosis of an internal ligament tear
- Detection, staging, post-treatment evaluation of tumor of the knee
- Suspected osteochondritis dessicans if the clinical picture and plain x-rays are not confirmatory
- Suspected osteonecrosis if the clinical picture and plain x-rays are not confirmatory
- Persistent knee pain/swelling and/or instability (gives way) after an injury which has not responded to conservative management (ice, rest, elevation, medication, non-weight bearing, physical therapy), plain x-rays have failed to demonstrate a fracture or loose body, and the clinical picture is unclear.
- Persistent knee/pain swelling and/or instability (gives way) not associated with an injury after a 3-6 week trial of conservative treatment
- If specifically requested by a consulting physician (orthopedist or rheumatologist)

Addendum: An MRI is not indicated for:

- Diagnosis of osteoarthritis or rheumatoid arthritis
- Diagnosis of torn meniscus, loose body, or osteochondritis dessicans when the clinical examination and x-rays are diagnostic. If there is a true "locking" of the knee in flexion rather than "catching" in extension, this is indicative of loose body or torn meniscus
- When the MRI results will not alter the treatment plan of an anticipated surgical procedure

OCULAR DISEASE – Referral for Vision Loss or Eye Pain

Criteria – The CMS program does not cover routine eye care, including refractions. The program will cover critical eye services necessary to allow a patient to work and to relieve pain. Referral for refractions is covered only for patients experiencing vision loss to the extent that it interferes with work and basic life functions. All conjunctivitis is treated by primary care.

Patient History (one of these 3 must be present)

1. ↓ visual acuity (provide visual acuity)
2. Ocular pain
3. Photophobia

Physical Exam (one of these 3 must be present)

1. Injection of vessels around the cornea
2. Corneal opacification
3. Pupil abnormalities

Refer to Ophthalmologist

OPHTHALMOLOGY - CATARACTS

Criteria for Surgical Removal

History (both required)

- Functional Impairment - employment affected
- Failure of vision to improve with prescription changes and other corrective measures

AND

Physical Exam

- Visual Acuity in best eye must be worse than 20/50 with corrective lenses. (Covered for both eyes)

Addendum: A cataract may be removed at any level of acuity if it precludes diagnosis or treatment of another ocular disease, such as diabetes or natural disease.

OPHTHALMOLOGY - GLAUCOMA

Criteria for referral to Ophthalmology

Patient History

- Loss of the mid-peripheral visual field
- Elevated intraocular pressure
- Advanced age
- Being black
- Family history of glaucoma
- Other risk factors
  - Myopia
  - Diabetes mellitus
  - Migraine
  - Hypertension
  - Long-Term corticosteroid use
  - Previous eye injury

Physical Exam

- Suspicious looking optic nerve head

Addendum: According to A.A.O. (American Academy of Ophthalmology)

> 60 years ——— exam every 2 years
> 40 years in blacks
20-39 years in blacks – exam every 3-5 years

OPHTHALMOLOGY

Annual diabetic retinal exam does not require a TAR
Criteria – Ophthalmology referral is approved for the following conditions and circumstances

Chalazion (is a cyst in the eyelid that is caused by inflammation of the meibomian gland)

The primary treatment is application of warm compresses for 10 - 20 minutes at least 4 times a day. This may soften the hardened oils blocking the duct and promote drainage and healing.

Topical antibiotic drops or ointment are sometimes used for the initial acute infection, but are otherwise of little value in treating a chalazion. Chalazia will often disappear without further treatment within a few months and virtually all will resorb within two years.

If they continue to enlarge or fail to settle within a few months, then a referral to an Ophthalmologist is appropriate. Smaller lesions may be injected with a corticosteroid or larger one may be surgically removed using local anesthesia.

Criteria for referral to Ophthalmology

Patient History
Persistent Lesion (by the 3rd month or longer)

Failure of Treatment (one of two)
Conservative therapy with antibiotic and warm compresses times two months
Local injection of a corticosteroid

Blepharitis (inflammation of the eyelids)

Many forms of treatment will improve blepharitis, including both antibiotic or steroid eye drops, and certain oral antibiotics. Unfortunately it may recur when any treatment is ceased. Recommend a regime of daily eyelid cleaning which is both effective and can be continued safely long-term. Simply cleaning the eyelids with a face cloth during every bath or shower may be a good system for a patient.

Criteria for referral to Ophthalmology

Patient History – Failure of improvement despite treatment
Physical Exam – Persistent Inflammation of the lid margins

OPHTHALMOLOGY

Criteria – Ophthalmology referral is approved for the following conditions and circumstances

Iritis (or Uveitis) Iritis is inflammation predominantly located in the iris of the eye. Inflammation in the iris is more correctly classified as anterior uveitis. The ciliary body can also be inflamed and this would then be called iridocyclitis.

Criteria for referral to Ophthalmology:

Patient History (all three required if no physical findings present)

1. Photophobia
2. Moderate pain
3. Vision is blurred

Physical Exam (any one item)

1. Redness of the sclera
2. Red halo around the cornea
3. Discharge may be present, but it is clear

Cataract (an opacity that develops in the crystalline lens of the eye or in its envelope)

Criteria for referral to Ophthalmology:

Patient History

Blurred vision (provide visual acuity)

Physical Exam

Cornea is clouded and cataract is seen on fundus exam

OPHTHALMOLOGY – Follow-up Examination Guidelines

DIAGNOSIS:	**ANTERIOR ISCHEMIC OPTIC NEUROPATHY** – every 2 weeks for 2 visits, then every 3-6 months
DIAGNOSIS:	**BLEPHARITIS** – up to 2 visits annually
DIAGNOSIS:	**CATARACT** - If immature cataract, every 12 months. If post-operative – covered in global, every 3 months. If post capsule thickening, every 6 months. If best corrected visual acuity is 20/40 or worse in the best eye, every 6 months. If following surgery in eye #1, when best corrected visual acuity is 20/40 in the remaining eye, every 6 months.
DIAGNOSIS:	**CHLOROQUINE RETINOPATHY** – every 6-12 months
DIAGNOSIS:	**CORNEAL ABRASION** – every 1-2 days until healed
DIAGNOSIS:	**CORNEAL ULCER** – every 24 hours until healed
DIAGNOSIS:	**CYSTOID MACULAR EDEMA (CME)** – every 6 weeks to 3 months, depending on medication used.
DIAGNOSIS:	**DIABETES MELLITUS** (DM), - annually for retina exam With retinopathy – every 3-6 months
DIAGNOSIS:	**DIABETIC MACULAR EDEMA** – every 3 months
DIAGNOSIS:	**EPIRETINAL MEMBRANE (ERM)** – every 3 months
DIAGNOSIS:	**GIANT CELL ARTERITIS (VASCULITIS)** – as often as needed based on the stability of the patient and nature of steroid therapy
DIAGNOSIS:	**GLAUCOMA (chronic)** – Every 3 months
DIAGNOSIS:	**GLAUCOMA SUSPECT** – every 3-6 months depending on the pressure

OPHTHALMOLOGY – Follow-up Examination Guidelines

DIAGNOSIS: **HYPERTENSIVE RETINOPATHY** – every 6-12 months

DIAGNOSIS: **IRITIS, UVEITIS, IRIDOCYCLITIS** – every 1-2 weeks if acute, every 1-3 months if chronic depending on medication used and severity of the inflammation

DIAGNOSIS: **MACULAR DEGENERATION** – every 1-12 months depending on severity and progression of the disease

DIAGNOSIS: **MACULAR HOLE** – every 1-3 months

DIAGNOSIS: **OPACIFICATION OF POSTERIOR CAPSULE** – once a year

DIAGNOSIS: **OPTIC NEURITIS** – as often as needed

DIAGNOSIS: **PSEUDOPHAKIA** – once a year

DIAGNOSIS: **RETINAL DETACHMENT** – as often as needed before or after surgery

DIAGNOSIS: **RETINAL VEIN OCCLUSION (Central or Branch)** - Every month for 3 months, then every 3 months until stable, then every 6 months as needed

DIAGNOSIS: **RETINITIS PIGMENTOSA** – once a year

DIAGNOSIS: **STEROID EYE DROP USE** – once a year

DIAGNOSIS: **STEROID SYSTEMIC MEDICATION** – once a year

DIAGNOSIS: **TAMOXIFEN RETINOPATHY** – every 12 months, including Visual Field

DIAGNOSIS: **VISUAL FIELD DEFECT** – once a year

DIAGNOSIS: **VITREOUS DETACHMENT OR FLOATER** – with symptoms such as flashes of light, every 3-6 months, otherwise once a year

DIAGNOSIS: **VITREOUS HEMORRAGE** – every 1-3 weeks, ultrasound as needed

OPHTHALMOLOGY - PTERYGIUM

Criteria for Referral and Surgery: Pterygium is fibrous material that forms in the eye and covers part of the cornea. This benign condition often occurs in persons chronically exposed to dust and outdoor conditions. Referral for surgery is only necessary when vision is impaired.

Patient History

Visual interference (provide documentation)

AND

Physical Exam

Extension onto or over cornea to the extent that vision is impaired

OPTOMETRY- Coverage for Glasses

Criteria for CMS coverage of glasses or replacement:

- Vision defect by Snellen testing of equal to or > 20/50 or change in any meridian by at least 1.0 Diopter from the previous prescription
- Correction required for employment

Changes in Prescription:

- Any meridian change by at least 1.0 diopter
- Astigmatic correction of .5 diopters or more

Replacement:

- Replacement of glasses - 1x in 12 months if broken, lost or stolen

Not a Benefit:

- Reading glasses
- Routine refractions without any noticeable change in vision

OTITIS MEDIA

Criteria for Referral to ENT: Acute otitis media resolves most of the time in 2-8 weeks. Treatment is done in primary care. Chronic serous otitis media refers to a persistent collection of fluid in the middle ear. This usually resolves spontaneously, or is accompanied by allergic rhinitis. The following criteria are used for referrals to ENT:

Patient History (one present)

- 3 or more episodes of acute otitis media in 6 months
- Persistent pain and pressure in the middle ear longer than 3 months

Physical exam (one present)

- Visualization of the tympanic membrane shows bulging, retraction or fluid layer
- Inflammation of the tympanic membrane
- Reduced mobility testing of the tympanic membrane by:
  - tympanometry
  - acoustic reflectometry

Decreased hearing by audiometry

PAIN MANAGEMENT

Criteria for Referral to a Pain Specialist: Most patients with chronic pain are managed by primary care. In 2007, the CMS program was expended for approval of long term chronic pain medications. Referral to a Pain Specialist is appropriate if the diagnosis of chronic pain is uncertain despite a work-up by primary care, if a procedure such as an epidural injection is indicated, or if specialist help is needed with pain management

Patient History (most of the following is present in the clinical record)

- Failure of adequate medication treatment, NSAIDS, opiates
- Failure of an individualized proactive pain control plan
- Failure of Relaxation exercises
- Failure of a home exercise program
- Patient has knowledge of and expectation of his or her pain management
- No presence of psychiatric disorders
- Measurement of pain on a scale of 1-10
- Failure of therapeutic modalities, heat, cold, physical therapy
- No evidence of drug addiction or drug-seeking
- Previous surgeries are listed

AND

Physical Exam

- Restriction of movement
- Sites of tenderness
- Neurologic signs with neck or back pain, especially radiculopathy

AND

Tests Done in Primary care (Imaging and other studies) are required

PEPTIC ULCER DISEASE

Criteria for Referral to GI or Surgery: Peptic ulcer refers to gastric and duodenal ulcers. The most common causes are chronic H. pylori infection and the use of NSAIDs. Gastric ulcers carry an increased risk of cancer. Medical management by primary care is usually sufficient to treat peptic ulcers. Referral to GI is done for endoscopy (EGD). Because of the effectiveness of modern medical management, surgery for peptic ulcer disease is rarely necessary.

Patient History

- Intractable and recurrent epigastric pain
- Adequate trial of a PPI medication (at least 2 months therapy)
- Treatment for H. pylori done and not successful

AND

Physical Exam

- Epigastric tenderness is present.

AND

Labs

- H. pylori testing
- Fecal occult blood

PET SCAN (POSITRON – EMISSION TOMOGRAPHY)

Criteria for the Procedure: A PET scan differs from a CT or MRI by imaging cellular function of tissue. It is most useful in cancer diagnosis and follow-up. PET scanning is now being applied to other organ systems such as the heart. The CMS only covers PET scanning when it is critically necessary and no other modality will give the information.

- Diagnosis, staging and restaging or the following clinical conditions:
  - Lung cancer (non-small-cell)
  - Esophageal cancer
  - Colorectal cancer
  - Lymphoma
  - Melanoma
  - Head and neck malignancy
  - Brain malignancy
  - Thyroid cancer
  - Breast cancer
  - Cervical cancer

- To determine appropriate treatment, surgery v. chemotherapy

- To determine if a tumor has been completely eradicated, post treatment.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

Criteria for Referral and Treatment: PT, OT and ST are approved only for clinical conditions which require them for return to function. In general, an evaluation and 2 follow-up treatments are approved initially, unless the condition dictates longer therapy (such PT in a long bone fracture or OT/ST post stroke).

- Ordered by the PCP when office education is not sufficient
- Ordered by specialist
- Post-op surgery
- Must include aggressive patient education and home exercises
- Greater than 12 patient visits require case management
- Document action of progress and modalities used
- Chronic low back pain – unresponsive to medication management

Patient History must include a description of limitations

Physical Exam must include deficits or impairment

Patient Responsibility

- Motivation to follow exercise program
- "No shows" and non-compliance will lose approval for further treatment

Addendum: Extension of therapy requests must be accompanied by original evaluation and comparative documentation to allow assessment of improvement in function.

PLANTAR FASCIITIS

Criteria for Referral to a Podiatrist or Orthopedist: Most patients with plantar fasciitis are managed by primary care. All patients should have their feet and shoes evaluated. Initial treatment includes heel lifts or shoe inserts. Decreased activity, stretching and weight loss are part of conservative treatment. Only persistent and severe cases are approved for referral:

Patient History

- Heel Pain:
  - Increased upon awaking
  - Located just anterior to the heel

AND

- Failure to respond to conservative management
  - Modify activity
  - Limit weight bearing (running)
  - Oral anti-inflammatory medications
  - Heel pads (OTC products)
  - Hot soaks with no symptomatic relief
  - Exercises to strengthen lower leg muscles and to increase flexibility of the Achilles tendon and Hamstrings.

AND

Physical Exam

- Pain to palpitation at plantar aspect of the calcaneous
- May have positive heel squeeze test
- Often associated with pes cavus or pes planus

PODIATRY

Referral to Podiatry or an Orthopedist for foot problems is covered by CMS for conditions which are critically necessary for work and/or activities of daily living.

Most common foot problems, such as plantar fasciitis and skin conditions, are managed by primary care.

Proper shoes and the use of inserts treat most foot problems, along with weight loss and stretching.

Routine foot examinations, including the annual diabetic foot exam, are done by primary care.

CMS does not cover referral or treatment of toenail fungus infestation (tinea unguum).

Criteria for Referral to a Podiatrist or an Orthopedist

- Major foot deformity, including a bunion which is causing pain and inability to work or perform ADLs
- Failure of conservative care provided by PCP
- Heel Spurs – failure to respond to conservative care and requiring an injection

PROSTATECTOMY

Criteria for Referral and Surgery: There are now multiple options for treating prostate disease other than surgery. Medications are very effective for benign prostatic hypertrophy (BPH). Surgery is only one of many options for treating prostate cancer. The decision to remove the prostate requires a specialist in Urology or Urologic Oncology.

Patient History (one of four)

- History of urinary retention despite treatment with medications
- Presence of incontinence
- Recurrent urinary infections
- Nocturia – more than twice/night despite treatment with medications

AND

Physical Exam (one of three)

- Enlarged prostate or with malignant nodules
- > 20 c.c. post-voiding residual despite medications
- Persistent Hematuria

AND

Diagnostic (one of four)

- IVP - obstructing prostate
- U/S - hydronephrosis
- Positive needle biopsy for cancer
- Abnormal creatinine level, or decreased creatinine clearance

RHEUMATOLOGY - INCLUDING RHEUMATOID ARTHRITIS

Criteria for Referral: Referral to Rheumatology must have evidence of active collagen vascular (autoimmune) disease. A thorough history, musculoskeletal exam and laboratory studies below must be done. The treatment of Rheumatoid Arthritis has changed to the early use of disease modifying medications to prevent further disability. An accurate diagnosis of the condition should occur at the primary care level.

Patient History (three of six)

- Chronic pain
- Loss of joint function
- Limitation of self-care (Noticeable joint inflammation, stiffness, deformity)
- Morning stiffness, warmth, redness, swelling, and deformity
- Any loss of finger function
- Generalized illness

ACR – Diagnostic Criteria (three of seven)

- Morning stiffness of at least 60 minutes duration
- Arthritis of three or more joints
- Arthritis of hand joints
- Symmetric arthritis - Present for six weeks
- Rheumatoid nodules
- Serum Rheumatoid Factor
- Radiographic changes

Physical Exam

- Fusiform swelling of small joints, especially the hands

Laboratory (the first four must be provided)

- ANA (Antinuclear antibodies)
- Rheumatoid Factor
- ESR (Erythrocyte Sedimentation Rate)
- CBC, electrolytes, creatinine, liver function tests, UA
- Synovial fluid analysis

SECOND OPINION

Criteria for Approval: CMS may authorize a request for a second opinion from the patient or practitioner, or CMS may suggest a second opinion when any one of the following circumstances are present:

- A more cost-effective treatment option is available.
- Conservative therapy has not been attempted or has not had sufficient time to show results.
- Practitioner or patient disagrees with the diagnosis and/or plan of treatment recommended by the specialist.
- Practitioner or patient is seeking an alternate treatment option that may improve the outcome.
- Patient/practitioner relationship is hindered.
- Geographic and/or other obstacles prohibit patient form accessing care.

SEPTOPLASTY

Criteria for Referral and Surgery: The CMS program does not cover surgery on the nose for any cosmetic purpose. Approval for referral and surgery would be approved only if the abnormality markedly interferes with work or daily function.

Patient History (one of two)

- Documented nasal trauma of recent origin with causes significant nasal obstruction
- Persistent serous otitis media secondary to nasal obstruction and poor Eustachian tube dysfunction

AND

Physical Exam

- Dislocation of septal cartilage causing complete or near complete obstruction of the nasal cavity

SINUSITIS – Acute and Chronic

Criteria for Referral: Most acute and chronic sinusitis is managed by primary care. Underlying causes such as allergy and infection are determined and treated by primary care. Referral is only necessary for persistent disease that markedly interferes with work or daily function.

Patient History

- Persistent obstruction beyond two months which interferes with function.
- Failure to respond to 2-3 courses of antibiotic therapy

Physical Exam

- Nasal exam - documenting purulent discharge
- Palpable sinus tenderness

Treatment (all tried)

- First and Second line antibiotics used for up to 6 weeks
- Decongestant therapy for up to 6 weeks
- Nasal corticosteroids used for up to 6 weeks without benefit

Diagnostic

- Sinus x-rays or CT scan confirm obstruction

COUNTY MEDICAL SERVICES
STATEMENT OF MEDICAL NECESSITY
REQUEST FOR SLEEP APNEA STUDY

Patient Name _____ **SSN** _____

Date _____ **CMS Eligible From:** _____ **To:** _____

Clinic _____ **Requesting Practitioner** _____

Please complete the information below to determine the medical necessity of a Sleep Apnea Study.

Patient History of Sleep Disturbance

Average number of hours of sleep each night _____

Does patient nap during the day? ☐ Occasionally ☐ Daily

Snoring: Soft ☐ Loud ☐

☐ Falls asleep while driving ☐ Excessive daytime somnolence

☐ Wakens with a sensation of choking or gasping

Medical Conditions

☐ Hypertension
☐Controlled ☐Malignant

☐ Depression

☐ Diabetes ☐Type I ☐Type II
Controlled ☐Yes ☐No

☐ Allergic Rhinitis

☐ Asthma

☐ Nocturia

☐ Obesity

☐ Heart Disease

Life Style Behaviors

Number of caffeinated beverages per day _____

Amount of alcohol consumed ☐ Daily _____ ☐ Occasionally _____

Smokes more than 1 pack of tobacco per day ☐ Yes ☐ No

Does the patient have a stable home environment? ☐ Yes ☐ No

Medical Exam (all required)

Height _____ Weight _____ Blood Pressure _____ Neck circumference _____

Adeno-tonsillar enlargement ☐ Yes ☐ No

Maxillo-mandibular malformation ☐ Yes ☐ No

Medications (list all)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The practitioner has discussed the treatment options with the patient ☐ Yes ☐ No

If a CPAP is indicated, the patient is willing to tolerate the inconvenience of the treatment (equipment, noise, dryness). ☐ Yes ☐ No

SLEEP APNEA STUDY

Criteria for Referral: Sleep Apnea is common among obese people and people with upper airway obstruction. The attached sleep apnea form must be completed of help determine level of need.

Patient History: (two of first four)

- Chronic Loud Snoring
- Gasping or choking episodes
- Excessive daytime sleepiness
- Cognitive difficulties
- *Stable home situation. (required)
- *Willingness to use C-PAP machine if recommended (required)

Physical Exam:

- Obesity, including nuchal obesity
- Hypertension
- Nasopharyngeal narrowing
- BMI > 35

TENS Unit

Criteria for Approval: May be indicated for patients with chronic pain disorders who are refractory or have responded to the modalities and who have demonstrable relief from a TENS trial. TENS units will only be provided on a rental basis. No TENS rental will be authorized without a trial.

A completed referral, which fully documents indications for a TENS unit.

- Refer patient to PT for TENS trial with two visits.
- PT to report results to Medical Director

Addendum: TENS rental may be approved for 3 months at a time, providing the patient remains eligible.

THYROID DISEASE

Criteria for Referral: **Hypothyroidism** is evaluated and treated at the primary care level. Referral to Endocrinology would only be approved for severe cases or when the primary care physician is unable to control the patient. Most patients with **Hyperthyroidism** should be referred to Endocrinology to be evaluated and to explore treatment options. Hyperthyroidism secondary to taking excessive thyroid medication is managed by primary care. **Thyroid nodules** or other thyroid masses are referred to Endocrinology and to either Interventional Radiology or General Surgery for biopsy or other surgery. Occasionally, referral to Endocrinology is needed to evaluate and recommend treatment for severely ill or cardiac patients.

Patient History (Indications for Referral)

- For fine needle aspiration of solitary nodules
- For treatment of thyroid cancer
- To confirm the diagnosis and treatment plan for hyperthyroid patients
- For radioactive iodine therapy
- When lab values are ambiguous, especially in sick or elderly patients

THYROIDECTOMY

Criteria for Referral and Surgery

Patient History (one of two)

- Family history of thyroid cancer
- Recurrent cystic lesions

AND

Physical (one of three)

- Presence of a thyroid nodule or mass
- Lymphadenopathy or metastasis
- Cystic lesion > 4cm

AND

Diagnostic (one of four)

- Fine needle aspiration, positive for cancer
- I_{131}, scan-positive
- Chronic thyroiditis by microsomal antibodies
- ↑ calcitonin levels

TMJ - TEMPOROMANDIBULAR JOINT DISORDER

Criteria for Referral and Any Procedure such as Arthroplasty: TMJ refers to persistent pain and other symptoms such as clicking in the temporomandibular joint of the jaw, just in front of the ear. This common problem has many causes: arthritis, dental problems, and stress causing grinding or clenching the teeth (bruxism). TMJ is initially evaluated by primary care to determine the most likely cause. Dental referral should be done before a medical specialist if there is evidence of malocclusion or other dental problems. Other possible referrals include counseling, physical therapy and ENT, which are approved based on these criteria:

Patient History (two of four)

- Pain or difficulty opening mouth
- Jaw locking
- Clicking, popping or crepitus sound
- Past history of rheumatoid or osteoarthritis

AND

Physical Exam (one of three)

- Presence of facial asymmetry
- Limited movement of the jaw
- Tenderness and/or crepitation over TMJ joint on palpation

Dental evaluation should be done on most patients

Past Treatment (two of three)

- Muscle relaxants
- Anti-inflammatory agents
- Splint/oral appliance

TONSILLECTOMY AND ADENOIDECTOMY (T & A)

Criteria for Referral for Surgery: T & A was once an almost universal procedure in America. Upon the realization the tonsils and adenoids are lymph nodes and part of the upper respiratory immune system, their removal has become uncommon. Chronic persistent infection unresponsive to antibiotics and chronic obstruction are the common reasons for referral to ENT and removal of the glands.

Patient History (one of these)

- Repeated episodes of acute tonsillitis (four or more) in past year with failure of resolution despite antibiotic therapy
- Persistent obstruction of breathing and swallowing
- Recurrent otitis media with persistence of fluid pressure secondary to enlarged adenoids causing obstruction to the Eustachian tubes

Physical Exam (one of these)

- Markedly enlarged and chronically infected tonsils
- Tonsils causing oral obstruction
- Peritonsillar abscess
- Adenoid obstruction of the Eustachian tubes (by imaging)

Adenoidectomy alone (one of these)

- Nasal obstruction resulting in sleep apnea
- Chronic otitis media with effusion secondary to adenoids

TRIGGER FINGER

Criteria for Referral and Surgical Correction: Trigger finger, or stenosing tenosynovitis, is a condition in which one or more fingers (including the thumb) is/are caught in a bent position. This finger may straighten with a snap, like a trigger being pulled and released. The finger remains in a bent and locked position in more severe cases. Referral and surgery is CMS approved when correction of the trigger finger is critically necessary for work or daily function.

Patient History (one of first two)

- Pain at the interphalangeal joint of forefinger or thumb
- Failure of injectable steroids
- Affecting work (obtain work history) - required

AND

Physical Exam (one of two)

- Nodular thickening at the M.C.P. joint
- Catching or locking of the P.I.P. joint with extension of finger

TYMPANOPLASTY

Criteria for Referral: Tympanoplasty is repair of the tympanic membrane, or eardrum. The procedure is done for persistent perforations of the eardrum.

Patient History (two of three)

- Recurrent infection of the middle ear
- Chronic hearing loss interfering with work or daily function
- Previous antibiotic therapy and observation fails to result in healing of the perforation.

AND

Physical Exam and Testing

- Perforation of Tympanic Membrane
- Hearing loss of > 40 db by autiometry

TYMPANOTOMY

Criteria for Referral: Tympanotomy, also known as myringotomy, is a surgical incision of the tympanic membrane, or eardrum. The procedure is done to perform surgery in the middle ear, or more commonly to insert drainage tubes because of persistent fluid in the middle ear.

Patient History or Medical Records documenting one of the following:

- Cholesteotoma (collection of tissue in the middle ear)
- For insertion of typanostomy tubes (documented need by consult)
- To explore the middle ear for hearing loss (> 40 db) or other pathology

VARICOSE VEINS

Criteria for Referral and Surgery: Varicose veins are veins that become enlarged or twisted. Usually these occur in superficial veins of the leg, especially in women during and after pregnancy. Most varicose veins cause no significant medical problems and treatment is not necessary. CMS would only cover referral and surgery for varicose veins that cause major problems with work or daily function, and never for cosmetic purposes.

Patient History (both present)

- Associated with severe, constant pain and/or stasis ulceration.
- Prescription compression stockings have failed after at least a six-month trial.

Note: Patient unlikely to require coronary artery bypass grafting in the future.

Physical Exam (one of these present)

- Recurrent superficial phlebitis (two or more occasions)
- Stasis ulcer that is recurrent (three or more occasions) or not responding to conservative therapy after six weeks.

Contraindication: Occlusive arterial disease (moderate to severe)

- Recent deep vein thrombophlebitis
- Pregnancy
- Congenital abnormalities of deep veins

VERTIGO

Criteria for Referral: Vertigo is dizziness associated with a feeling of movement, such as the room spinning. Vertigo is usually caused by a problem with the inner ear balance mechanism (vestibular system), or in the brain. The most common cause of vertigo is benign positional vertigo (BPV), a temporary condition common in middle age and the elderly. Temporary vertigo is also caused by inner ear infections, usually a virus, called labyrinthitis. Other more serious causes include toxicity with medications, ischemia to the brain (TIA or stroke) or brain tumors. If the vertigo is caused by an inner ear problem, it is referred to as peripheral vertigo. If the cause is in the brain, it is referred to as central vertigo. The initial assessment of vertigo, including maneuvers to determine if it is peripheral or central, is done by primary care. Referrals for peripheral vertigo usually go to ENT, while central vertigo is referred to Neurology.

Patient History

- True rotatory vertigo elicited by a rapid head movement in a non-axial plane, e.g. rolling over in bed
- If other neurologic symptoms are present, such as weakness, severe headache or hearing loss, early referral is indicated
- Failure of Treatment for BPV including:
  - Medications
  - Epley Maneuvers
    - Assume position of Dix-Hallpike with the affected ear down then slowly rotate head in the opposite direction. Then, rotate head and whole body another 90 degrees, resume sitting.

AND

Physical Exam

- Dix-Hallpike maneuver
  - Patient moves from a sitting to a supine position with the head hanging over the edge of the bed or table and rotated 45 degrees; ear down. Bi-lateral testing
  - Affected ear facing ground → vertigo and rotating movement of eyes or nystagmus indicated peripheral vertigo and most likely BPV.
  - If this is negative, a central cause of vertigo is considered and neurologic testing is indicated.

Diagnostic Testing

- Audiometry should be done to document hearing loss
- A CT scan (for acoustic neuroma) or MRI (for brain tumor or mass) may be requested by primary care

WOUND MANAGEMENT

Criteria for Referral to a Specialist or to a Wound Care Clinic: Patients with diminished circulation or low oxygen in the blood may have chronic wounds that if not treated aggressively become more complicated. Most wound management is done by primary care, but complicated wounds may require the evaluation and management recommendations of a wound care specialist or clinic. CMS would authorize such a referral and treatment procedures if critically necessary for wound healing.

Patient History (all must be present)

- Chronic ulcers-not healed within 30 days of occurrence.
- Failure of standard wound therapy.
- No measurable signs of healing.

Physical Exam

- Chronic stage 3 & 4 pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis.